Unlikely Allies

Accountable Care Organizations and Geriatric Emergency Departments Partner to Reduce Avoidable Hospitalization Admissions for Seniors

NAACOs Fall Conference
Washington, D.C.
October 10, 2025
11:30am - 1:00pm

Meet Our Presenters

Ana Tuya Fulton, MD, MBA
President and COO of Integra Community Care Network, Chief Population Health Officer, Care New England

Kevin Biese, MD, MAT
Director of Geriatric Emergency Medicine, Vice-Chair of Academic Affairs, Clinical Associate Professor, UNC Chapel Hill

Tony Rodriguez, MD
Medical Director, Continuing Care Network
UNC Health Alliance

Stephen Meldon, MD
Director Emergency Department
Cleveland Clinic

West Health Learning and Action Networks in VBC

West Health is dedicated to lowering the cost of healthcare.

Our research, policy, advocacy, and philanthropy enable successful aging for seniors.

GARY & MARY west foundation™ EST. 2006

westhealth™ institute

westhealth™ policy center

OUTCOMES-BASED PHILANTHROPY

APPLIED MEDICAL RESEARCH

POLICY RESEARCH AND ADVOCACY

Funded by Gary and Mary West, our mission includes enabling seniors to successfully age in place.

We are focused on improving access to high-quality, affordable health and support services, while preserving and protecting dignity, quality of life and independence.

Starting With The WHY

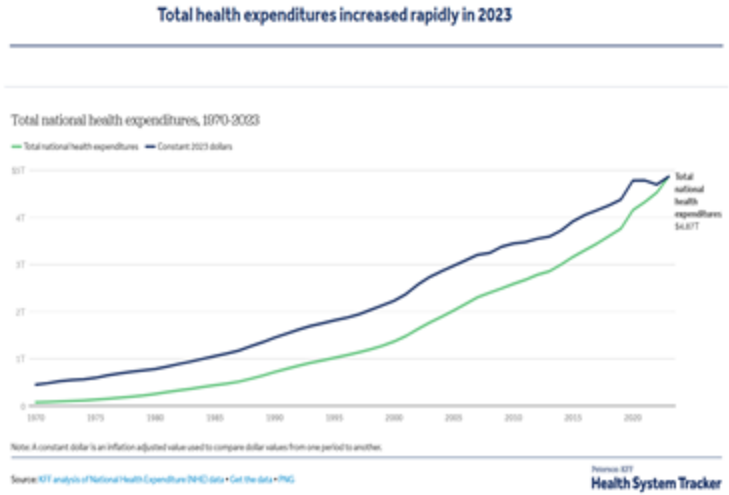
Meet Jim
Father of 6, grandfather of 17, electrical engineer, and avid fly fisherman.

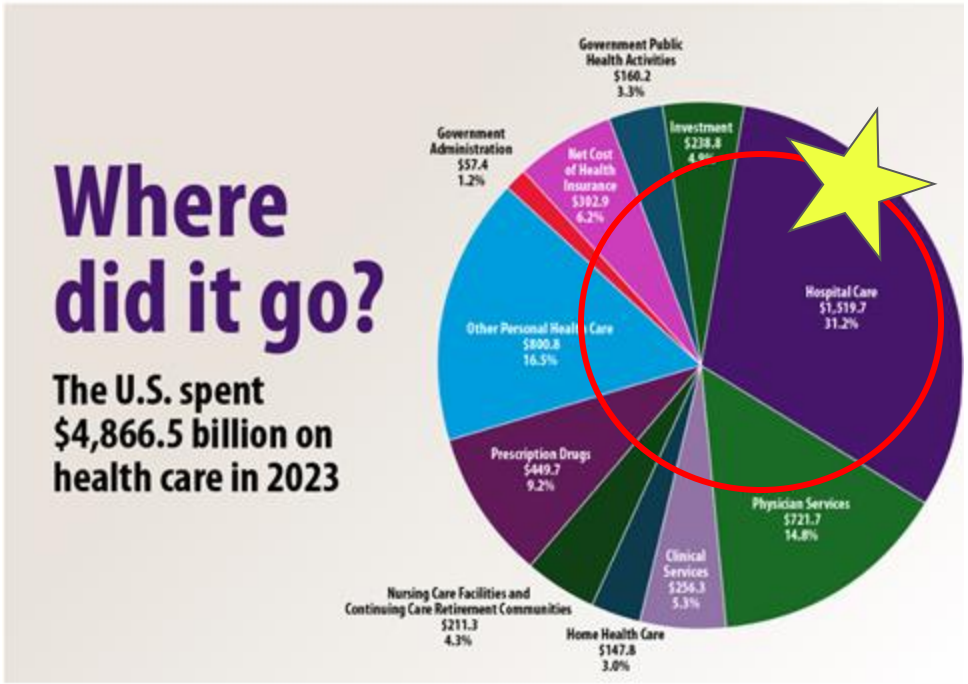
- CAD
- CKD with transplant
- Advanced Parkinson's w/dementia
- Aggressive metastatic skin cancer

In 18 months, Dad had 7 hospital admissions
(6 preceded by ED visits, none in accredited GEDs).

He was not an attributed beneficiary of any
Value-Based Care Organization.

Dedicated to Solving Healthcare Ecosystem Challenges:





- Peak Boomers turn 85 in 2030
- 11,000/day eligible for Medicare
- 2025 projected healthcare spend ~ $5.6 Trillion
  - 1/3 spent on hospital-based services
- Spending per capita > $16,000/year
  - expected to grow 4-6% next several years
- Burden of chronic disease, social drivers of health, & affordability of healthcare & insurance increasingly associated with adverse health outcomes and cost to taxpayers

Achieving the Promise of Accountable Care through Learning and Action

- Innovation, care redesign, process improvment – getting the most out of healthcare to keep people healthy and at home
- Strategies for shifting from low value, higher cost services to *high value, lower cost services.*
- We are ALL patients & families, motivated to create a better system of care for ourselves & our loved ones
- Consider additional pathways that can be utilized/developed - look outside the box for new partners, **the ED is not your enemy**!!

Geriatric Emergency Departments

Geriatric Emergency Departments (GEDs)

STAFFING	LEVEL 3	LEVEL 2	LEVEL 1
1 MD/DO with evidence of focused education for geriatric EM	✓	✓	✓
1 RN with evidence of focused education for geriatric EM	✓	✓	✓
Physician champion/Medical director		✓	✓
Nurse case manager/transitional care nurse present > 56 hrs/week		✓	✓
Interdisciplinary geriatric assessment team includes at least 2 roles		✓	✓
Interdisciplinary geriatric assessment team includes at least 4 roles		✓	✓
At least 1 executive/administrative sponsor supervising geriatric ED program		✓	✓
Patient advisor/patient council			✓

Similar to the concept of pediatric emergency departments, GEDs incorporate specially trained staff, who conduct extended assessments and take steps to make sure the patient experience is more comfortable and less intimidating for older adults.

ACEP GERIATRIC ED ACCREDITATION PROGRAM

ACCREDITED GERIATRIC

ACCREDITED GERIATRIC

ACCREDITED GERIATRIC

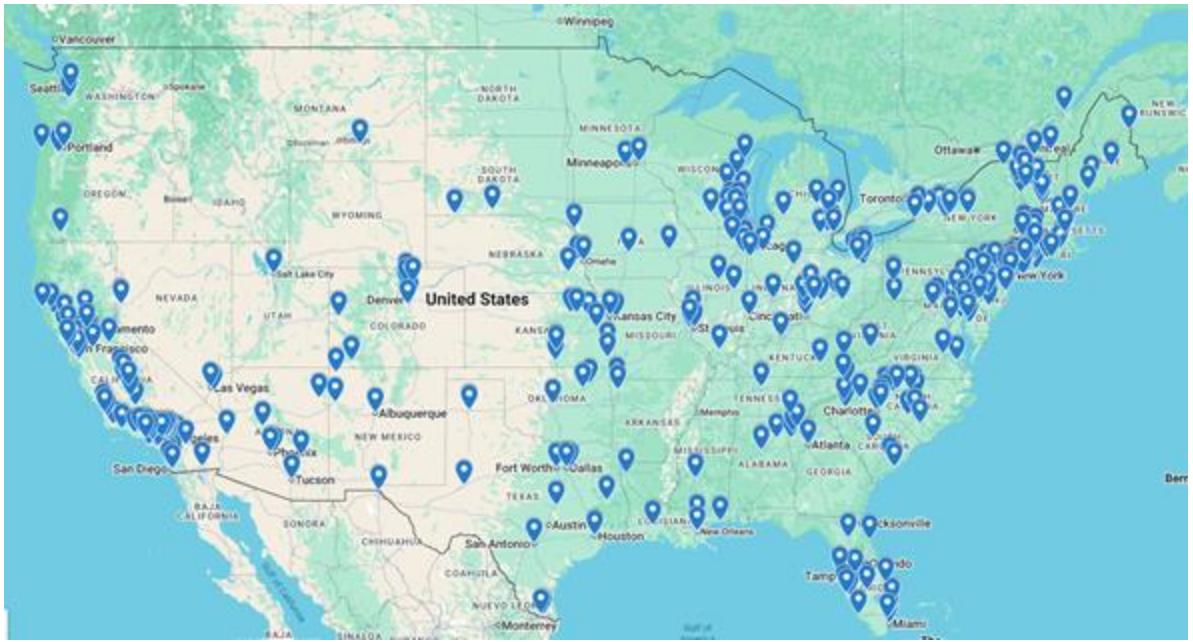
Total = 500+

Geriatric Emergency Department Team's Priorities

DECREASE READMISSIONS	**Recent update from a SE US site:** 13 Estimated Readmissions Prevented over first 3 months
DECREASE ED REVISITS IN HIGH-RISK POPULATIONS	**Midwest GED site:** 9% decrease in ED revisits **JAGS article:** PT in the ED associated with reduced 30- & 60-day revisits
INCREASE MARKET SHARE	**Actual case:** Urban safety net hospital seeking more Medicare patients
ENABLE BETTER CENSUS MANAGEMENT	**CFO of academic system in NE:** "I am tired of seeing the air-ambulance fly over us because we are on diversion. This can help us put our beds to better use."
INCREASE STAFF AND PATIENT SATISFACTION	Result seen at multiple health systems across all levels of accreditation

Action Item #1 for You Today

- Go to the GEDA website at www.acep.org/geda or scan the below QR code to find out where GEDs are located in your catchment area.



Recognizing Aligned Goals:

Value Based Care Organizations (VBCO) and Geriatric Emergency Departments

VBCOs and GEDs Have Aligned Interests

Older patients that go to a GED are ***less likely to be admitted*** to the hospital or ***return to the emergency department*** within 30 days. They also have ***substantially lower healthcare costs*** (more than $3,000 lower for Medicare beneficiaries) in the 60 days following an ED visit.

ED

- 60% of older adults **admitted** to hospital come **through** the ED[1]
- ED makes decisions with tremendous cost implications (average admit >$22,000 vs. discharge)[1]

REDUCE UNNECESSARY ADMISSIONS

CONNECT TO SERVICES

STANDARDIZE CARE

VBCO

- Lower odds of preventable ED visits[2]
- High use of evidence-based care coordination strategies[3]
- Improved preventative care quality performance[4]

Over **15% of all ED visits by adults 65+** in the U.S. are **occurring in a GED**

A Natural Alignment of VBCOs and GEDs

IAC Institute for Accountable Care

GED accreditation growth = increasing numbers of ACO beneficiaries being seen in GEDs

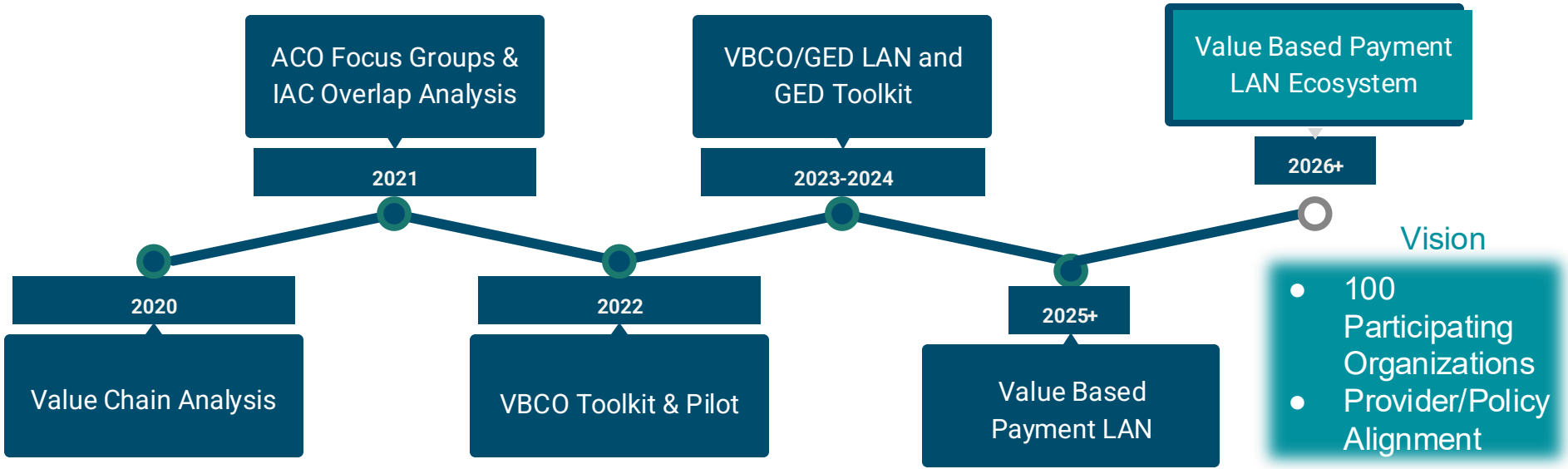
KEY METRIC	2019	2021	2023	Δ
ACOs with at least 1,000 patient visits to a GED	100	135	203	+103%
GEDs providing care to ACO beneficiaries	192	253	342	+78%
Total ACO ED visits occurring at a GED	1/3	1/4	N/A	-1/12
On average, ACO beneficiaries are visiting GEDs	Twice	Once	N/A	-1

Using the Data to Target your Beneficiaries

- 2023 Medicare claims data analysis
- Provides insight into the degree to which VBCO beneficiaries are using GEDs and the specific GEDs in which beneficiaires seek care
- “Other ACO” = ACOs with less than 100 unique beneficiaries were rolled together

UNC HEALTH®	Unique ACO Beneficiaries at UNC Medical Center Hillsborough - Level 2 GED		
ACO Name	**Unique ACO Beneficiaries using GED**	**Number of GED Visits**	**Allowed Charges for ACO Benes**
Duke Connected Care, LLC	873	1,355	$2,235,041
UNC Senior Alliance, LLC	2,086	3,441	$5,926,177
Non-ACO	2,520	3,743	$6,261,277
Other ACOs	909	1,219	$2,057,644

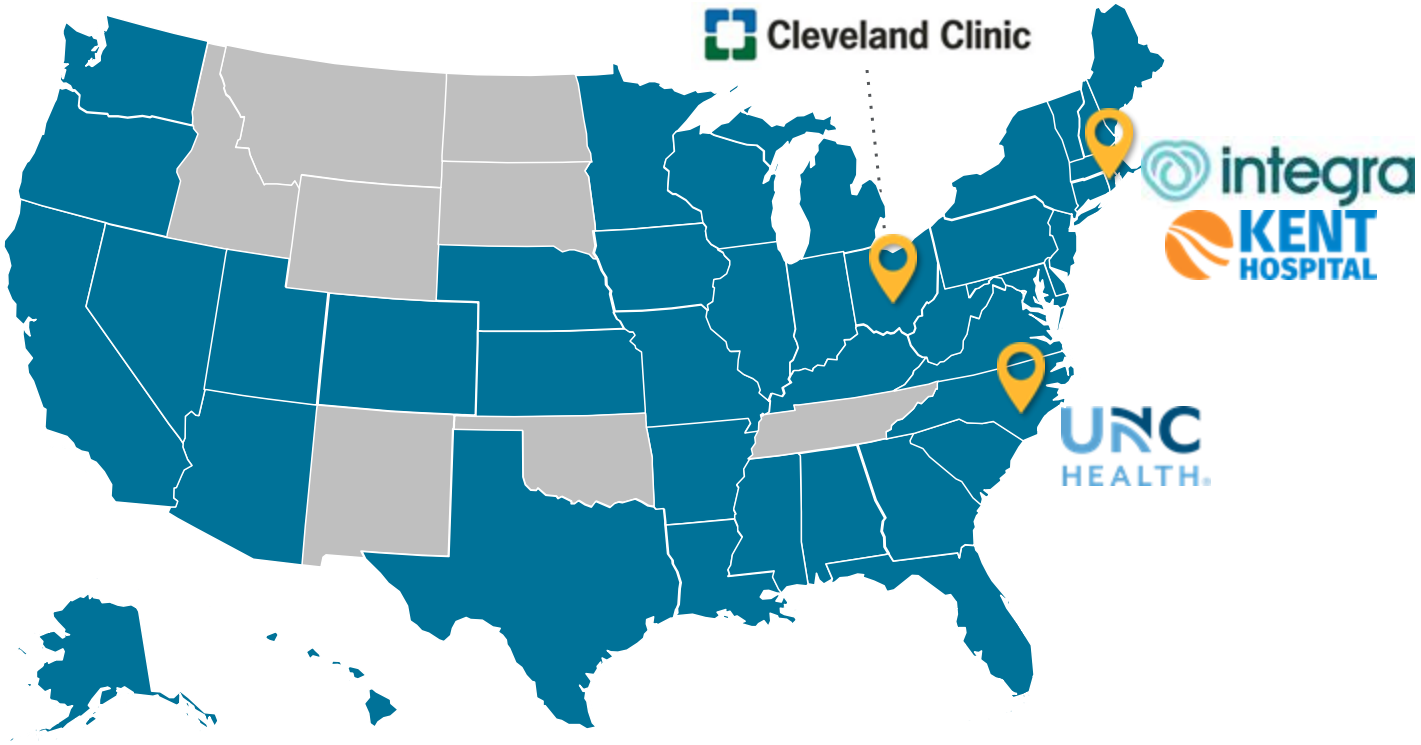
Vision for Accelerating the Adoption of Value Based Care



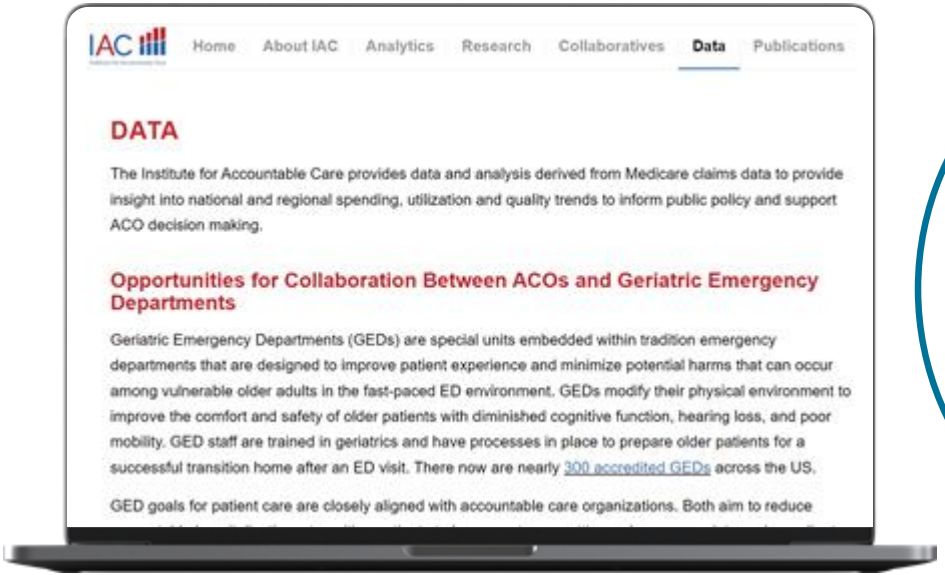
VBCO + GED

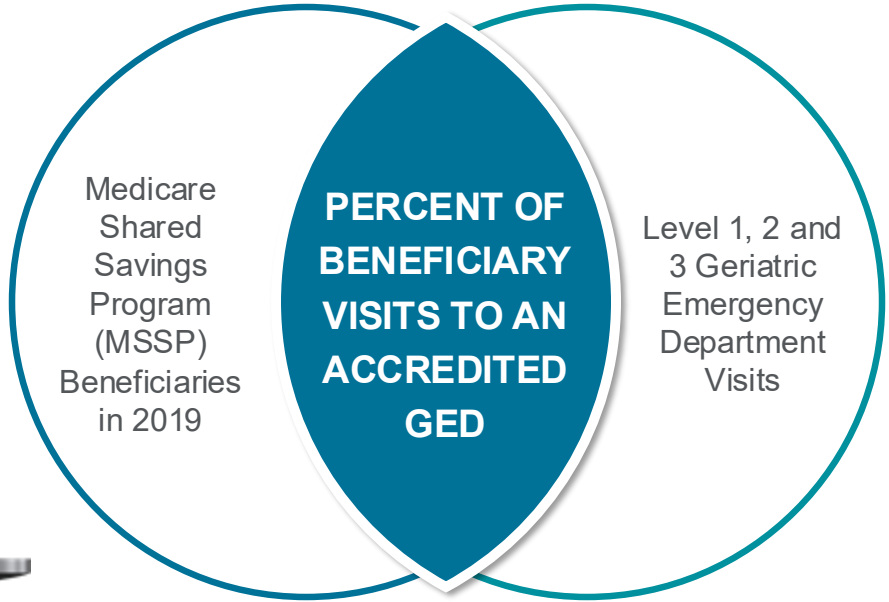
Learning and Action Network

Value-Based Care Organizations + Geriatric Emergency Departments: Pilot Participants



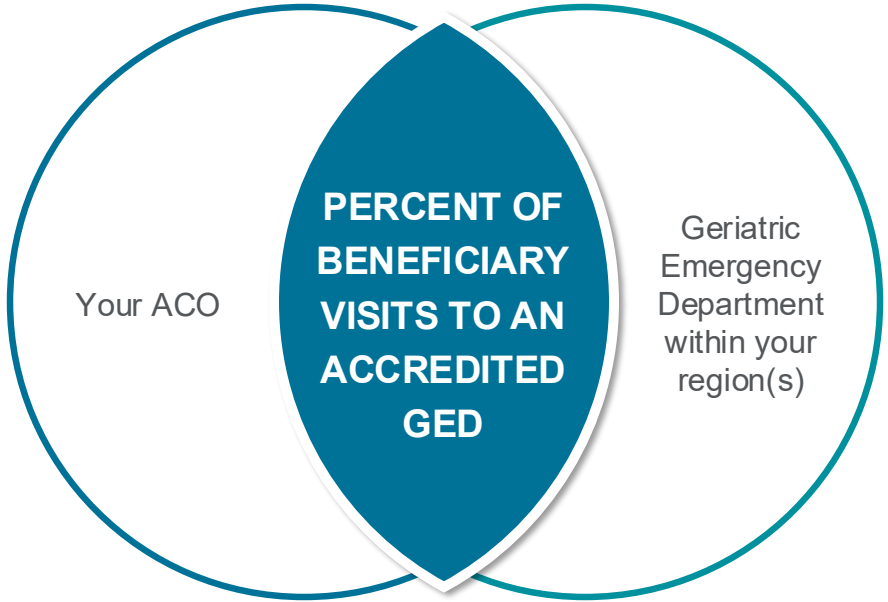
Pilot Participant Selection





Action Item #2 for You Today- Find your ACO/GED Overlap

- Go to the Institute for Accountable Care website at https://institute4ac.org/data/ or scan the QR code below to gain insight into the degree to which your VBCO beneficiaries are using GEDs and the specific GEDs in which beneficiaires seek care.



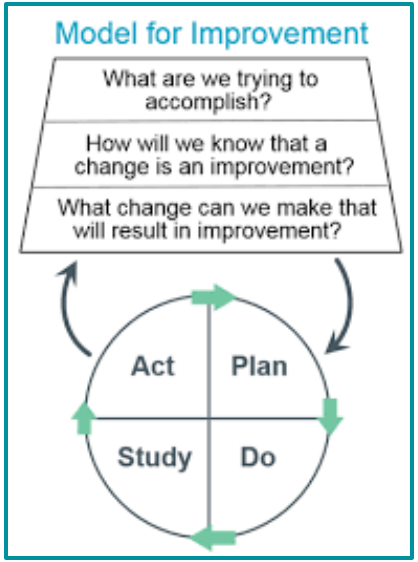
Learning & Action Network Overview

Shared Project Aims:

- Reduce admissions originating from GEDs resulting in associated 10% gross savings to the payor
- Objective evidence of program sustainability

Quality Improvement Focus:

- Care delivery redesign through the established "Model for Improvement"
  - Define Measurable Aims
  - Test Changes
  - Iterate, Implement & Scale



Implementation Support:

- Individual Team Improvement Coaching
- Monthly All-Team Coaching Calls
- Data Collection
- In-Person Learning Sessions

Integra Community Care Network, LLC

Existing Innovation: Integra at Home

- Integra Community Care Network had previously piloted and launched an acute care-at-home program known as “Integra at Home.”
  - Offers:
    - Home visits by paramedics and by clinical providers
    - Lab work and tests at home
    - 24/7 on-call service
    - Proactive reporting to primary care providers
    - 30 days of follow-up monitoring after discharge from an acute episode
  - These existing innovations accounted for Integra’s 162 averted admissions during the course of the LAN.

The Improvement Initiative: Embed Integra Nurse in Kent GED

- Embed a new Integra nurse into the GED to identify Integra members and collaborate with ED clinicians to disposition Integra members to Integra's home and community-based programs.

The Results as of September 30, 2024:

Existing Innovations Averted Admissions	New Improvement Initiatives Averted Admissions	Total Averted Admissions	Gross Service Savings
162	0	162	$1,743,120.00 (MSSP) $2,577,582.00 (BCBS)

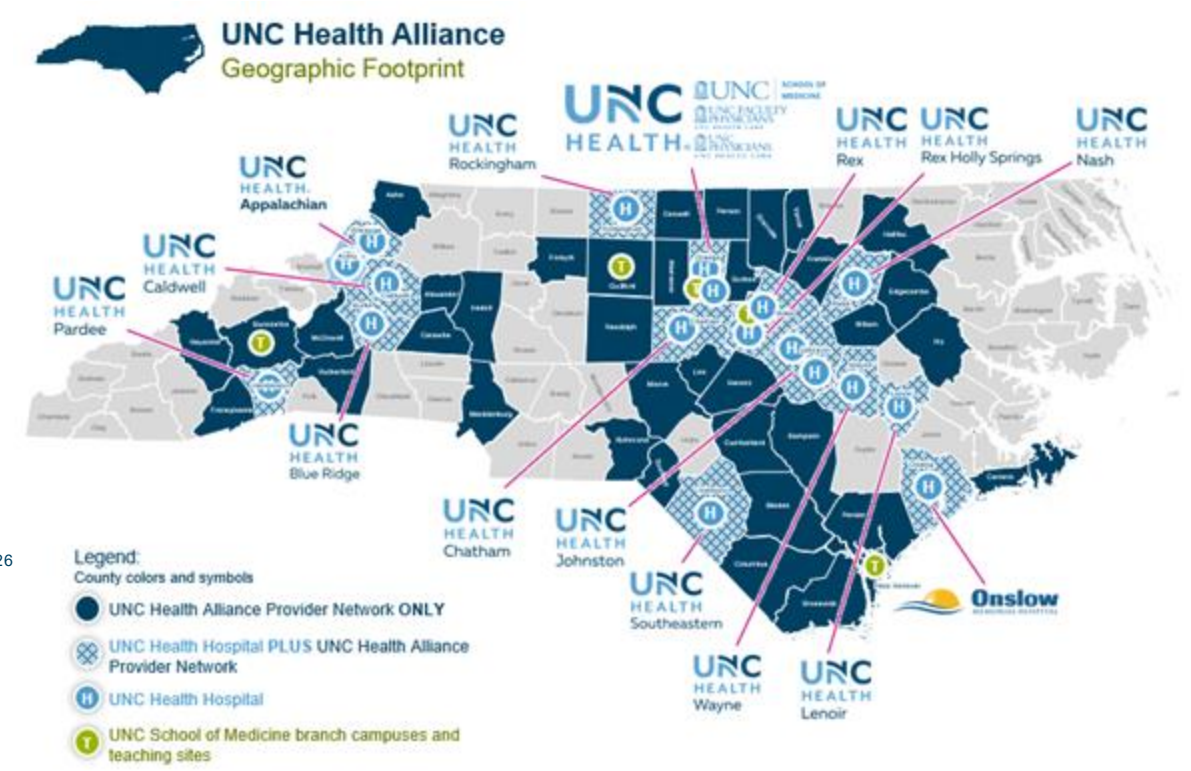
Challenges with Implementation

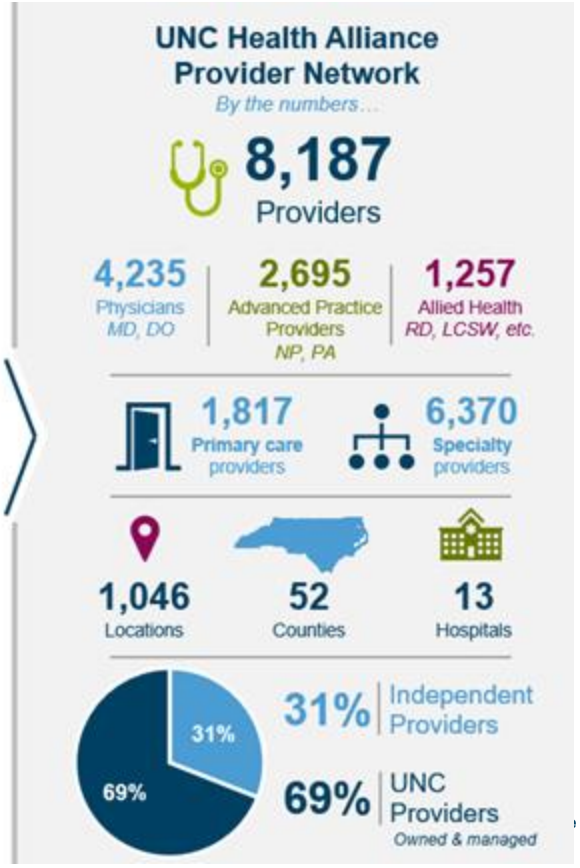
- Integrating a VBCO RN into the culture and clinical operations of the GED proved incredibly challenging for Integra.
  - No space located within the GED for VBCO RN to work. Office was located within Kent Hospital.
    - Office contained a desktop computer, which was required to input data into the EHR, requiring the VBCO RN to spend a considerable amount of time in the office away from the GED.
  - Lack of presence in the GED resulted in serious communication gaps with clinical staff and an inability to get appropriately ingrained into clinical operations, such as daily huddles, rounds or shift-change debriefs.

UNC Health Alliance

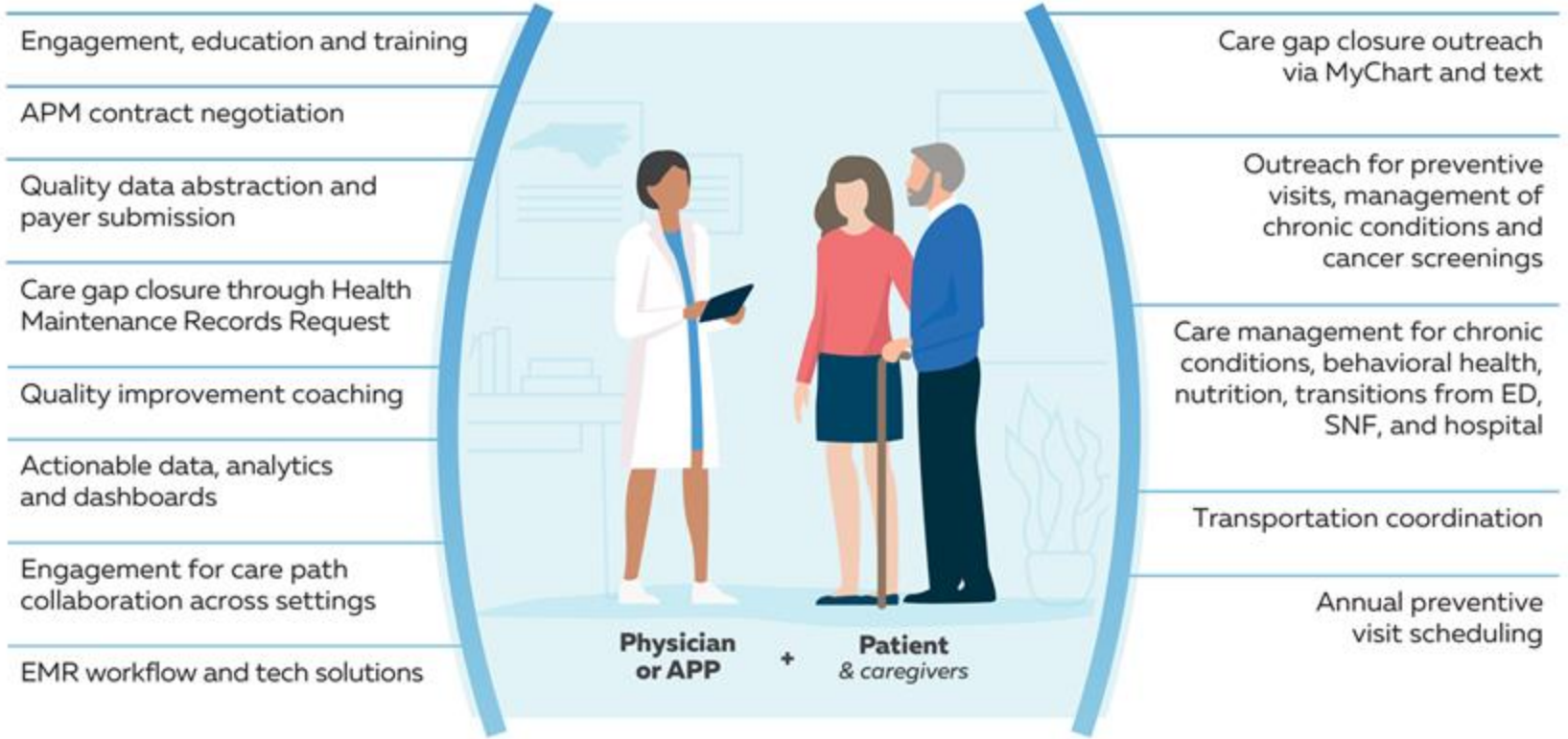
UNC Health Alliance covers 52 counties in NC with 1,046 locations

As of Sept 2025, UNCHA has grown to 8,187 providers; 1,817 primary care and 6,370 specialty providers

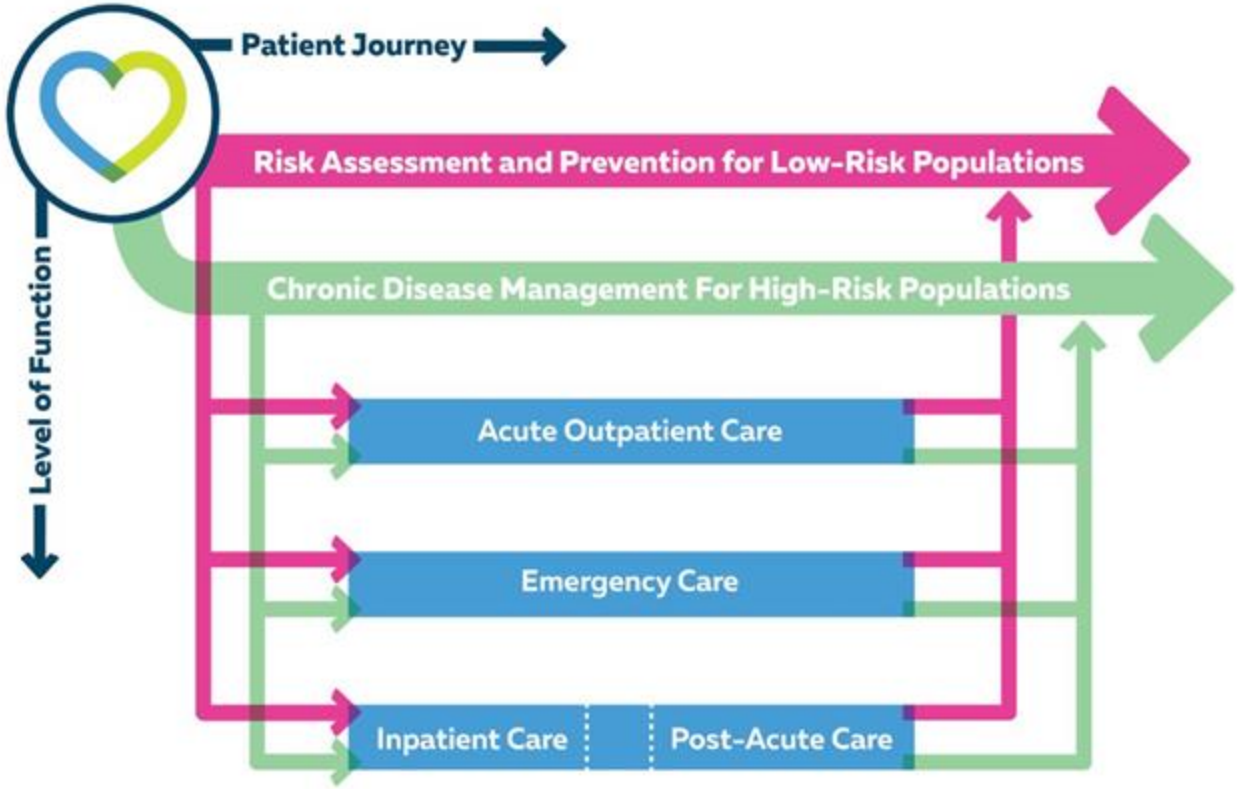




Offering clinical services aimed at improving outcomes and practice support to succeed in alternative payment models



Exploratory initiatives in care transitions led us to develop a larger framework for the ACO role within the transitions space



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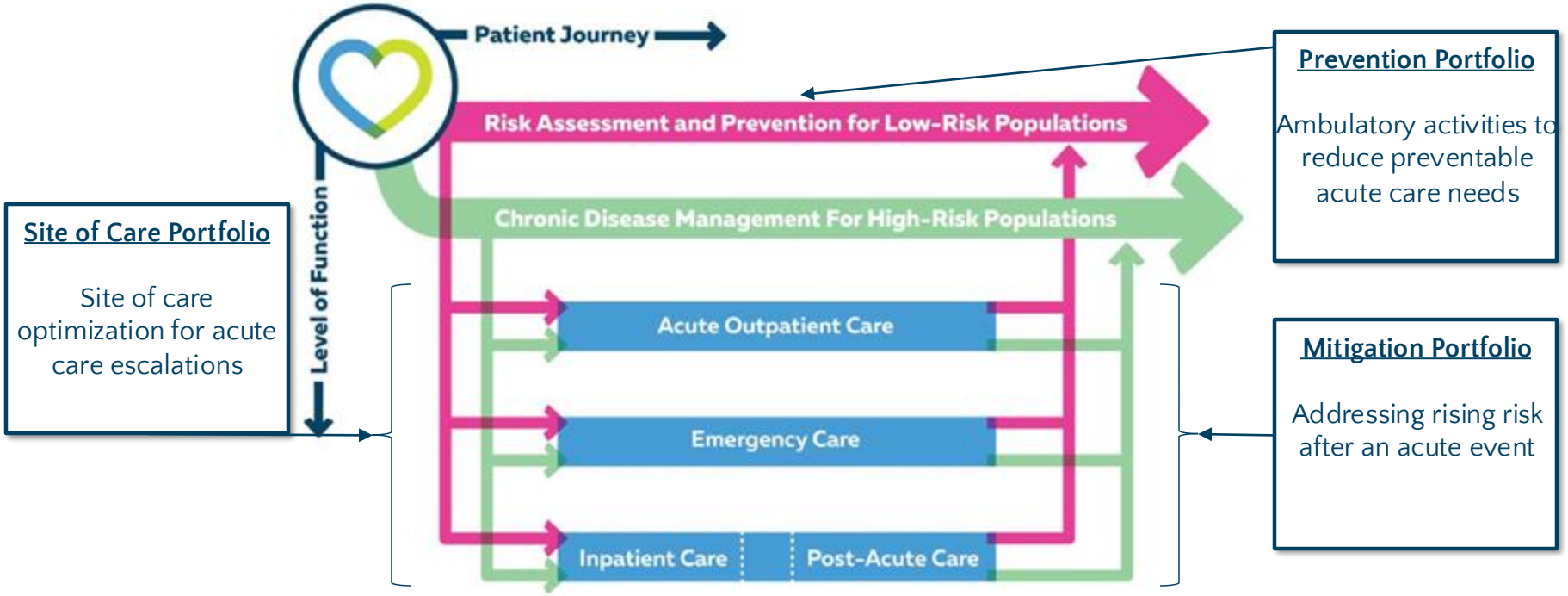
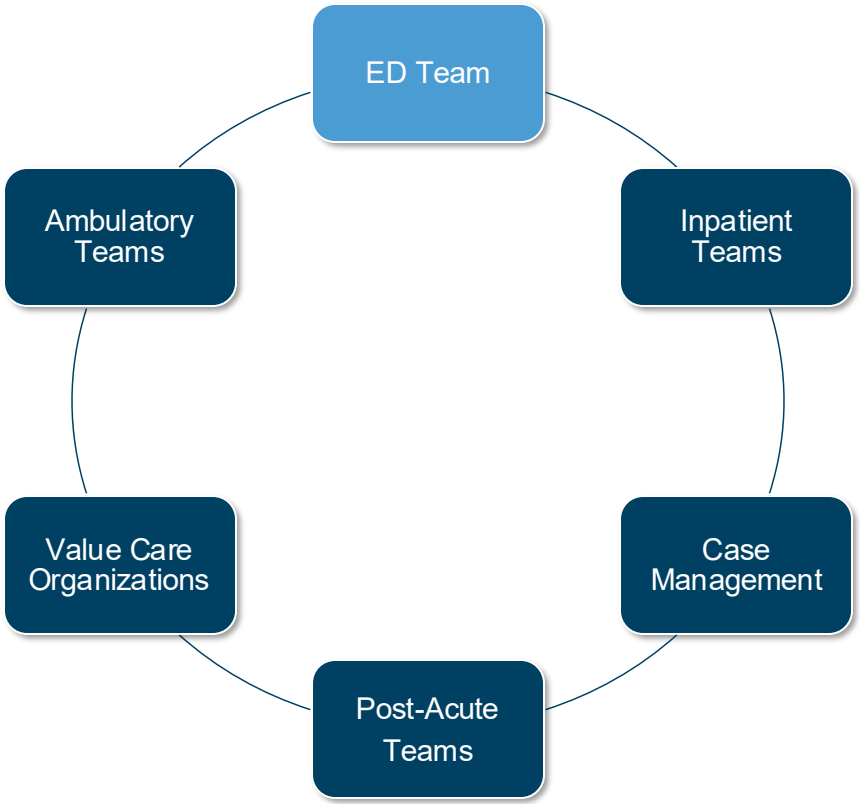


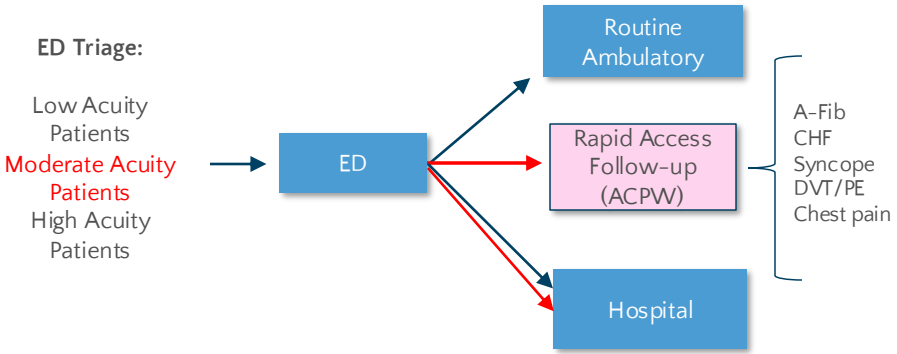
And a recognition that the ED is a critical partner in transitions space quality improvement



Transitions Improvement Initiative

Optimizing Rapid Follow-up Care Through Alternative Care Pathways

Baseline Concept



Consistent and **rapid** follow-up through alternative care pathways will reduce unnecessary hospital admission, total cost of care, improve ED throughput, and improve long-term clinical outcomes for patients

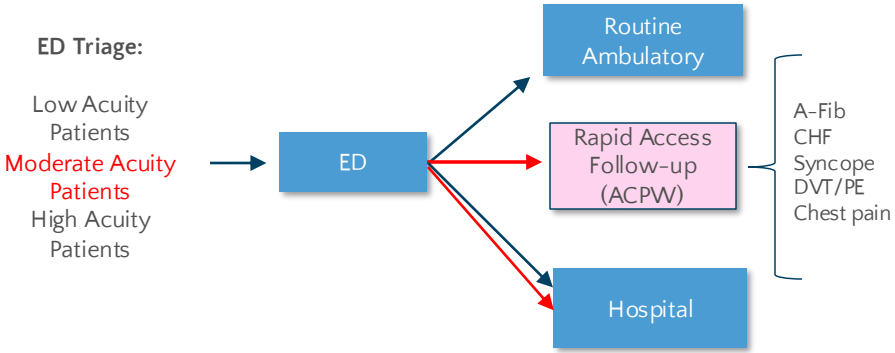
Existing Challenges

- 1 – Defining patient acuity
- 2 – Simplifying the referral process for clinicians
- 3 – Unifying the process across pathways
- 4 – Evaluating the financial impact outside of value care

ED provider feedback through A3 process was instrumental in understanding current state and conducting a gap analysis to drive solution creation

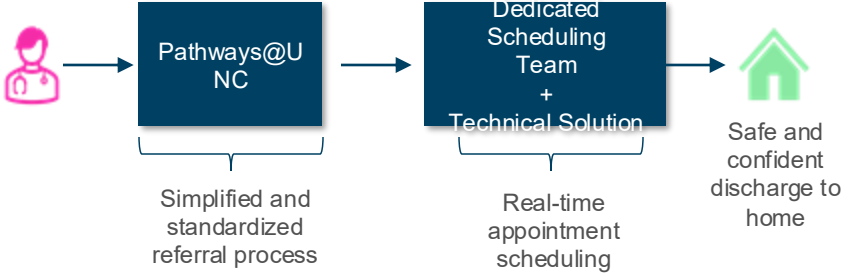
Optimizing Rapid Follow-up Care Through Alternative Care Pathways

Baseline Concept



Consistent and **rapid** follow-up through alternative care pathways will reduce unnecessary hospital admission, total cost of care, improve ED throughput, and improve long-term clinical outcomes for patients

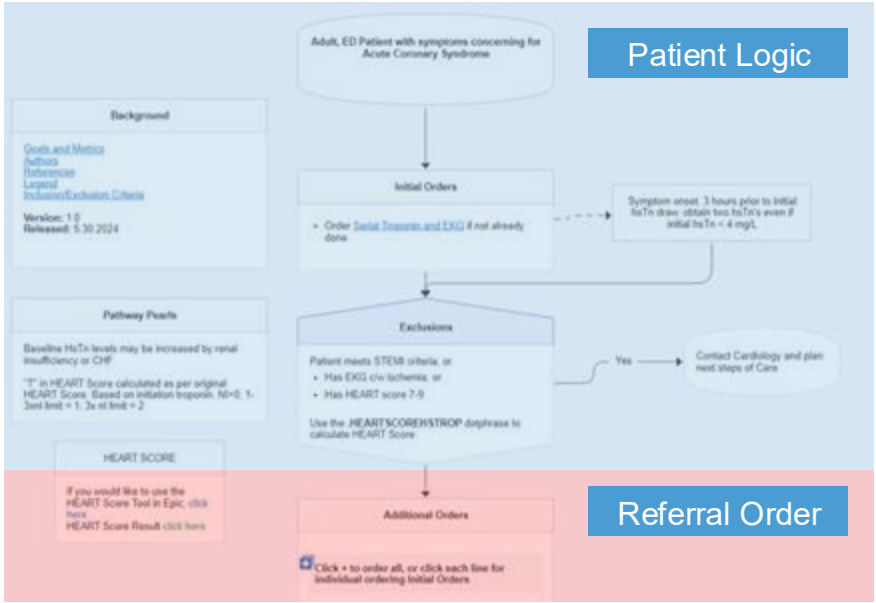
Streamlined Execution



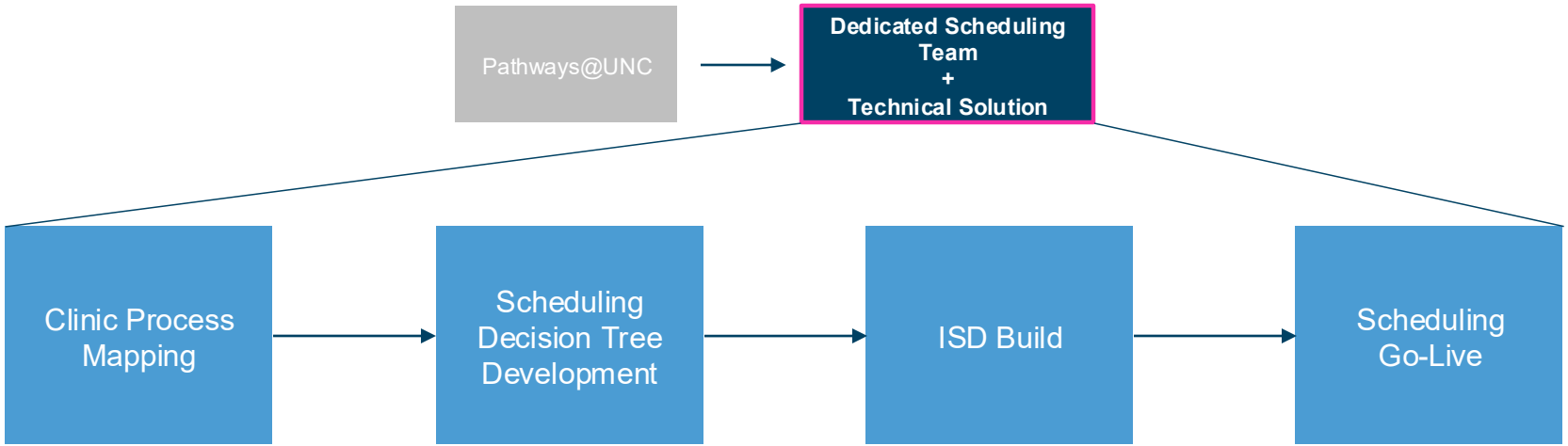
A cohesive, single end-to-end solution across all pathways to improve ED provider user experience and deliver an appointment slot in real time before patient discharge

Optimizing Rapid Follow-up Care Through Alternative Care Pathways: Pathways@UNC

- Epic-integrated disease-specific clinical algorithms
- In-algorithm ordering of diagnostics/therapeutics
- Algorithm populates with relevant Epic data
- **Logic defined by ED + subspecialty consensus creates precision patient targeting**
- **Referral order creates single pathway exit point and simplifies process**



Optimizing Rapid Follow-up Care Through Alternative Care Pathways:
Scheduling Solution Integration Process



Health Unit Clerk (HUC)-driven direct scheduling allows for a patient to leave the ED with a date/time for their follow-up appointment, improving confidence amongst ED providers

Optimizing Rapid Follow-up Care Through Alternative Care Pathways:
Stakeholder Accountability - Pathway Use and Capacity Management

- Extensive work to create easily accessible data dashboard for all stakeholders
- Created/adopted data definitions, informed by stakeholders, on relevant system metrics for timeliness of care, patient throughput, patient experience, and financial impacts
- ED clinicians held to metrics on pathway utilization (100% percent of providers opening pathway once) and captured opportunity (50% of in-scope patients referred
- Subspecialty clinicians held to metrics on sufficient access (time to scheduled appointment, schedule utilization metrics)

Optimizing Rapid Follow-up Care Through Alternative Care Pathways: Outcomes

- From 7/2024-4/2025 370 patients were diverted across five clinical pathways
- This early effort yielded a shared savings of $188,000 across value care and $580,000 hospital revenue (backfill volume adjusted for contribution margin)
- Preliminary estimates suggest that these figures represent 10-30% patient capture across relevant clinical conditions
- We anticipate increased patient capture with ongoing ED/subspecialty pathway iteration and expansion across other clinical conditions
- Balancing measures suggest high patient satisfaction and minimal adverse impacts on outpatient scheduling to date

Learnings To Date

- ED as a valuable partner in optimizing site of care – not an adversary
- Engage the ED at the beginning of an initiative and allow them to shape the outcome – they should not be the recipients of a solution they had no hand in creating
- Accurate cost modeling is challenging but rewarding – partnering with system finance to create bilateral understanding of payment models is essential
- The ACO has a valuable role as a convener between ED and subspecialty – there may be some challenges to bringing these groups together but it is worth the effort
- Ask for the metrics you need to measure for stakeholder buy-in – it will strengthen the value proposition with critical stakeholders

Cleveland Clinic

Existing Innovation: Geriatric Consult Program & Care Unit

- The Cleveland Clinic Main Campus Level 1 GED has an existing and robust geriatric consult program in the emergency department and an ED observation geriatric care unit (GCU) with a proven track record of significantly lower rates of hospital admission for older adults[3].
  - Offers:
    - Four-bed GCU in the ED's existing observation unit
    - Examined by a Geriatrician and a Care Management specialist
    - Physical Therapy consults
    - In-depth evaluation of cognition, mobility, social support, and potential for adverse drug interactions
    - Standardized care protocols
    - Early detection of delirium
    - Seamless care transitions
  - These existing innovations accounted for Cleveland Clinic's 199 averted admissions of Cleveland Clinic ACO's beneficiaries during the course of the LAN.

The Improvement Initiative: HomeCare+

- Integrate a new ACO program, “Home Care+”, that offers comprehensive, at-home, wrap-around services into GED disposition options.

The Results as of September 30, 2024:

Existing Innovations Averted Admissions	New Improvement Initiatives Averted Admissions	Total Averted Admissions	Gross Service Savings
199	1	200	$2,650,600.00

Challenges with Implementation

- Building clinical operations in alignment with program criteria
  - Early in their improvement effort, the GED was excited to identify and enroll their first patient in the ACO's new "Home Care+" program. Unfortunately, after getting far down the enrollment pathway, it was discovered the patient resided outside of the geographic catchment area for the program.
    - As a result, the Cleveland Clinic ACO & GED teams revised the established program criteria and amended the clinical operations to include vetting a patient's geographic location as a condition of enrollment, significantly delaying the roll-out of the program.

- At the conclusion of the LAN, the HomeCare+ program criteria and clinical operations were just being rolled out and demand for access to the program for non-ACO patients was growing.

Key Learnings

Key Learnings

1. Partnerships between Value-Based Care Organizations and Geriatric Emergency Departments can result in averted admissions and lower cost of care for older adults.

2. VBCO beneficiary identification by GED interdisciplinary clinicians is a key foundational building block for partnership.

3. Bi-directional awareness, education, engagement and communication is critical to effective partnerships.

4. Tracking averted admissions and creating feedback loops to determine why an averted admission was successfully executed are critical to ensuring ongoing success.

5. Improvement initiatives that focus on providing GED clinicians with low-burden, additional disposition options are the most successful in averting admissions.

Action Item #3 for You Today: Download The Toolkit

"There are no other similar resources to guide this work."

- 42-page operational Toolkit
- Designed for a Value Based Care audience
- Builds awareness of GEDs & outline steps to forge aligned partnerships
- Goal to reduce unnecessary admissions and improve care transitions
- A GED-facing toolkit is available too!

Summary of Action Items

1. Find out where GEDs are located in your catchment area.

2. Gain insight into the degree to which your VBCO beneficiaries are using GEDs and the specific GEDs in which beneficiaries seek care.

3. Download the Toolkit for Value Based Care Organizations and download the version for GEDS to share with your very own unlikely allies

Questions?

Thank You